STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF DUNELAND THE	110 BEVERLY DR CHESTERTON, IN 46304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00152400. Complaint IN00152400: Substantiated, no deficiencies related to the allegation are cited. Survey dates: July 21, 22, 23, 24 & 25, 2014 Facility number: 000150 Provider number: 155246 AIM number: 100267000 Survey team: Cynthia Stramel, RN-TC Heather Tuttle, RN Yolanda Love, RN Lara Richards, RN (7/21-7/24/2014) Census bed type: SNF/NF: 83 Total: 83 Census payer type: Medicare: 11 Medicaid: 61 Other: 11 Total: 83	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on July 29, 2014, by Janelyn Kulik, RN.			
F000225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further			

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	potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to promptly report a resident to resident verbal abuse altercation to the Administrator. The facility also failed to notify the State Agency of an allegation of verbal abuse for 2 of 2 allegations reviewed. (Resident #32) Findings include: 1. The record for Resident #32 was reviewed on 7/22/14 at 1:55 p.m. The resident was admitted to the facility on 5/20/14 from the hospital. The resident's diagnoses included, but were not limited to, major depression disorder, failure to thrive, high blood pressure, anxiety, and mixed personality traits. Review of a Physician Progress Note dated 7/16/14, indicated "remains argumentative on a daily basis. Also remains delusional regarding ability to	F000225	It is the practice of The Waters of Duneland to constitute our creditable allegation of compliance with all regulations requirements. 1. The actions taken are as follows: a. The allegation of abuse by R 32 was reported to the ISDH on 7/24/2014 b. The investigation of allegation was completed on 7/24/2014 2. The facilities actions taken to identify other residents are as follows: a. No other residents identified. 3. The measures put into place are as follows: a. All residents who went out on pass with family/friends were interviewed related to abuse b. All staff were re-inserviced on the abuse policy and reporting procedures. 4. The facility will monitor actions as follows: a. D.O.N. and/or designee will monitor the 24 hour board and nurses notes daily for any allegation of abuse. b. D.O.N. and/or designee will interview each resident who goes out on pass with family/friends for any allegations of abuse per	08/24/2014

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	care for herself. She continues to have problem solving skills. I do not see how she can live in the community independently as she has no problem solving skills and is frequently illogical and irrational." Review of Nursing Progress Notes dated 7/8/14, at 12:11 a.m., indicated "Resident came back from out on pass with her boyfriend. Complaints of being verbally abused in the parking lot. Writer encouraged resident to keep negative people out of her life and asked if she was ok. She informed writer that she was fine and writer stated, I'm sorry that he said mean things to you. Resident went to her room. At around 7:25 p.m. writers coworker said police were on the phone with him to ask writer to make sure resident was ok. As she was on the phone with police at that very moment describing her verbal abuse with an officer. Writer found resident to be on her cell phone talking to police and stated she's ok to coworker who was still on the phone with officer." (sic) Review of the 7/8/14 Social Service Progress Note indicated "reviewed with resident the telephone call with police last night. This has been a pattern in the past. When resident was living in community and is well documented by		facilities resident sign out book daily times 1 month, then 3 days a week times 3 months, then re-evaluate and determine the need to continue to monitor. c. The Administrator and/or designee will report all allegations of abuse to the ISDH per reporting requirements. d. The Administrator and/or designee will review all reports of concern and ISDH reportable occurrences at the monthly QA meeting and at the quarterly QA meeting with the Medical Director. The QA team will review audits for 6 months. Once 100% compliance is reached the QA team will determine when monitoring will stop. e. All new employees will be inserviced on abuse, abuse policy and reporting. 5. Our date of compliance is 8/24/2014	

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	Physician. Explained to resident she cannot continue to call police when they do argue. Resident wants the police to tell her friend not to talk to her that way. Resident agreed not to speak to her friend for awhile. Spoke with resident's friend (name) and told him they should not see or talk to each other for awhile." Continued review of Nursing Progress Notes dated 7/21/14, at 11:40 p.m., indicated "CNA came to writer and said she needs help in resident room with roommate of resident she was assisting. Resident was interfering with her care by walking to and from the bathroom while roommate was getting changed and ready for bed. CNA explained that she tried to explain to resident that she can't do that; that resident is entitled to her privacy while being changed. Resident went onto argue that CNA was bossy and she 'doesn't need to be talked to like she is 4 year old.' The other nurse and I tried to explain we were just trying to take care of all our residents equally. Resident stated she's seen all kinds of naked women and her and other resident were both girls so it doesn't matter. She went onto verbally abuse other nurse calling him fat and stated, 'You act just like my father and you're mean just like him.' This writer's coworker was not in anyway raising his voice or 'being mean' to			

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	resident. He was just trying to help writer explain that roommate is entitled to her privacy while being changed. While writer was continuing to talk/argue with resident because she kept bringing other negative things up into the conversation, another aid came to talk to writer about a different matter and resident accused aide of opening her bathroom door and looking at her privates. Two residents walked up and said nicely for resident to calm down and resident started to cuss at them. Other resident started cussing back and writer had to step in the middle and send them on their way. Writer escorted resident back to her room. Resident continued to come out of her room and argue with writer for 30 minutes." Interview with the Administrator on 7/24/14 at 10:00 a.m., indicated there had been no allegations of abuse the facility had reported to the State Agency regarding Resident #32. Further interview with the Administrator on 7/24/14 at 2:30 p.m., indicated he was not aware of the resident to resident altercation regarding the verbal aggression with Resident #32 and the other two residents. He further indicated at the time, that both incidents had not been reported to the State Agency.			

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	3.1-28(c)			
F000226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their Abuse policy regarding promptly reporting a resident to resident verbal abuse altercation to the Administrator and notifying the the State Agency of an allegation of verbal abuse for 2 of 2 allegations reviewed. (Resident #32) The facility also failed to ensure all contracted services, who had contact with the residents, were made aware of the Elder Justice Act. Findings include: 1. The record for Resident #32 was reviewed on 7/22/14 at 1:55 p.m. The resident was admitted to the facility on 5/20/14 from the hospital. The resident's diagnoses included, but were not limited to, major depression disorder, failure to thrive, high blood pressure, anxiety, and	F000226	It is the practice of The Waters of Duneland to constitute creditable allegation of compliance with all regulatory requirements. 1. The actions taken are as follows: a. The allegation of abuse by R32 was reported to the ISDH on 7/24/2012 b. The investigation of allegation was completed on 7/24/2014 2. The facilities actions taken to identify other residents are as follows: a. No other residents identified 3.The measures put into place are as follows: a. All residents who went out on pass with family/friends were interviewed related to abuse b. All staff were re-inserviced on resident to resident abuse 4. The facility will monitor actions as follows: a. D.O.N. and/or designee will monitor the 24 hour board and nurses notes daily for any allegation of abuse. b. D.O.N. and/or designee will interview each resident who goes out on	08/24/2014

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	mixed personality traits. Review of a Physician Progress Note dated 7/16/14, indicated "remains argumentative on a daily basis. Also remains delusional regarding ability to care for herself. She continues to have problem solving skills. I do not see how she can live in the community independently as she has no problem solving skills and is frequently illogical and irrational." Review of Nursing Progress Notes dated 7/8/14, at 12:11 a.m., indicated "Resident came back from out on pass with her boyfriend. Complaints of being verbally abused in the parking lot. Writer encouraged resident to keep negative people out of her life and asked if she was ok. She informed writer that she was fine and writer stated, I'm sorry that he said mean things to you. Resident went to her room. At around 7:25 p.m. writers coworker said police were on the phone with him to ask writer to make sure resident was ok. As she was on the phone with police at that very moment describing her verbal abuse with an officer. Writer found resident to be on her cell phone talking to police and stated she's ok to coworker who was still on the phone with officer." (sic)		pass with family/friends for any allegations of abuse per facilities resident sign out book Daily times 1 month, then 3 days a week times 3 months, then re-evaluate and determine the need to continue to monitor c. The Administrator and/or designee will report all allegations of abuse to the ISDH per reporting requirements d. The Administrator and/or designee will review all reports of concern and ISDH reportable occurrences at the monthly QA meeting and at the quarterly QA meeting with the Medical Director. The QA team will review audits for 6 months. Once 100% compliance is reached the QA team will determine when monitoring will stop. e. All new employees will be inserviced on abuse, abuse policy and reporting. 5. Our date of compliance is 8/24/2014 1. The actions taken are as follows: a. 100% audit of all contracted vendors was completed. All vendors did not have the Elder Justice Act information. 2. The facility actions taken to identify other are as follows: a. No residents were affected by the deficient practice 3. The measures put into place are as follows: a. All contracted vendors were sent letters explaining the Elder Justice Act and elder Justice Act information was also attached 4. The facility will monitor as follows: a. The Administrator and/or designee will	

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	Review of the 7/8/14 Social Service Progress Note indicated "reviewed with resident the telephone call with police last night. This has been a pattern in the past. When resident was living in community and is well documented by Physician. Explained to resident she cannot continue to call police when they do argue. Resident wants the police to tell her friend not to talk to her that way. Resident agreed not to speak to her friend for awhile. Spoke with resident's friend (name) and told him they should not see or talk to each other for awhile." Continued review of Nursing Progress Notes dated 7/21/14, at 11:40 p.m., indicated "CNA came to writer and said she needs help in resident room with roommate of resident she was assisting. Resident was interfering with her care by walking to and from the bathroom while roommate was getting changed and read for bed. CNA explained that she tried to explain to resident that she can't do that; that resident is entitled to her privacy while being changed. Resident went onto argue that CNA was bossy and she 'doesn't need to be talked to like she is 4 year old.' The other nurse and I tried to explain we were just trying to take care of all our residents equally. Resident stated she's seen all kinds of naked women and her and other resident were		monitor in monthly QA meeting contracted vendors to ensure that any new vendors have received the Elder Justice Act information. 5. Our compliance date is 8/24/2014	

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	both girls so it doesn't matter. She went onto verbally abuse other nurse calling him fat and stated, 'You act just like my father and you're mean just like him.' This writer's coworker was not in anyway raising his voice or 'being mean' to resident. He was just trying to help writer explain that roommate is entitled to her privacy while being changed. While writer was continuing to talk/argue with resident because she kept bringing other negative things up into the conversation, another aid came to talk to writer about a different matter and resident accused aide of opening her bathroom door and looking at her privates. Two residents walked up and said nicely for resident to calm down and resident started to cuss at them. Other resident started cussing back and writer had to step in the middle and send them on their way. Writer escorted resident back to her room. Resident continued to come out of her room and argue with writer for 30 minutes." Review of the current 6/1/2010 Abuse Prohibition Policy provided by the Administrator on 7/24/14 at 3:10 p.m., indicated "The resident has the right to be free from verbal, sexual, physical, and mental abuse corporal punishment, involuntary seclusion, and misappropriation of their property			

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	(collectively, sometimes referred to as "events"). Residents will not be subjected to such events by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members, or legal guardians, friends or other individuals. Verbal Abuse was the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to resident or their families or within their hearing distance, regardless of their age, ability to understand, or disability. The Administrator or the designee who is in charge of the facility, shall report any instances of suspected abuse, neglect, or misappropriation of resident property to the Department of Health as required." Interview with the Administrator on 7/24/14 at 10:00 a.m., indicated there had been no allegations of abuse the facility had reported to the State Agency regarding Resident #32. Further interview with the Administrator on 7/24/14 at 2:30 p.m., indicated he was not aware of the resident to resident altercation regarding the verbal aggression with Resident #32 and the other two residents. He further indicated at the time, that both incidents had not been reported to the State Agency.			

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	Interview with LPN #2 on 7/24/14 at 2:50 p.m., indicated he was one of the nurses working the night Resident #32 was having a verbal aggression with other staff and the two other residents. He indicated the resident was swearing and was very upset. He indicated two other residents came up to the resident and tried to calm her down, but Resident #32 became more upset and started swearing at them was becoming verbally aggressive. He indicated one of the residents started swearing back at the resident, and he had to physically step in between the residents to make sure Resident #32 was not going to hit one of them. He indicated Resident #32's verbal aggression was escalating. LPN #2 indicated he did not immediately notify the Administrator or Director of Nursing of the resident to resident altercation. 2. Interview with the Administrator on 7/25/14 at 9:30 a.m., indicated he had not sent out any Elder Justice Act information to the contracted services that enter the facility on a daily or monthly basis. He further indicated he had not given any information to Laboratory, Pharmacy, Registered Dietician, Ambulance Company or Hospice Services. The Administrator indicated those contracted services have			

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	employees that come into the facility and interact with the residents. 3.1-28(a)			
F000241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure each residents' dignity was maintained related to being called by their name during 1 of 1 meal observations. (Resident #50) The facility also failed to ensure volunteer groups knocked on the residents' doors prior to entering rooms for 1 of 2 residents reviewed for dignity of the 2 that met the criteria for dignity. (Resident #12) The facility also failed to ensure a resident's medical concerns were discussed in private without being overheard by others during a random observation for 1 resident. (Resident #31) Findings include:	F000241	It is the practice of The Waters of Duneland to constitute creditable allegation of compliance with all regulatory requirements 1. The action taken by the facility are as follows: a. R 50 was interviewed and was unable to recall incident in Main Dining Room on 7/21/2014 d/t cognition. R 50's son was also called r/t to incident in Main Dining Room and had no concerns. b. R 12 was interviewed by social services and activities. R12 was notified that church group will not be inviting resident to church services. c. R 31 was interviewed r/t Doctors appointment on 7/22. R 31 was unable to recall appointment or discussion of confidential medical information. 2. The actions taken to identify others are as follows: a. Interview with residents. No	08/24/2014

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WATERS OF DUNELAND THE	110 BEVERLY DR CHESTERTON, IN 46304

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	1. On 7/21/14 at 12:14 p.m., Resident #50 was observed in the Main Dining Room. CNA #3 was overheard calling the resident "honey" rather than by her name. The Director of Nursing was also observed in the dining room at this time calling residents "honey" rather than by their name. The record for Resident #50 was reviewed on 7/21/14 at 11:16 a.m. Review of the resident's Annual Minimum Data Set (MDS) Assessment dated 5/27/14, indicated the resident's Brief Interview for Mental Status (BIMS) could not be completed. The resident was described as having short and long term memory problems. 2. Interview with Resident #12 on 7/22/2014 at 11:00 a.m., indicated there was one church group that came to the facility every Saturday. She indicated the people in the church walk up and down the hallway and ask the residents if they want to go to church. They do not knock on my door and just walk in my room. The resident felt they should announce the services and not come into her room and bother her. She further indicated if my door was open they would look in my room and that bothered her. Another interview with the resident on 7/23/14 at 10:00 a.m., indicated it was		further residents effected by deficient practice b. The facility has identified residents who do not want to be invited to church services c. Residents were interviewed for discussion of disclosure of confidential medical information. No further residents were affected by the deficient practice. 3. The measures put into place are as follows: a. All staff was re-inserviced on Dignity, respect, resident rights and choice of visitors b. D.O.N. was re-inserviced on dignity and confidentiality c. Policy was put into place that states "It is the policy of this facility to maintain Resident Rights, Dignity, privacy and choice of visitors. d. Church groups were sent a letter regarding inviting residents and knocking on residents doors. Any new church groups involved at facility will be informed by letter. 4. The facility will monitor actions as follows: a. D.O.N. and/or designee will monitor dining rooms every meal for dignity and respect everyday times 1 month, then 3 times a week times 3 months, then re-evaluate and determine the need to continue to monitor. b. D.O.N. and or/designee will monitor nursing staff randomly for confidentiality of residents medical condition 3 times a week times 1 month, then 2 days a week times 3 months, then will determine if the need to monitor. c. Administrator and/or designee will	

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	still upsetting to her regarding the church group that comes to the facility every Saturday. She indicated she does not think they should be allowed to walk up and down the hallway and look in rooms, especially the children and they do not knock on the doors before entering. The record for Resident #12 was reviewed on 7/23/14 at 10:18 a.m. The resident's diagnoses included, but were not limited to, anxiety, insomnia, spinal bifida, chronic back pain, depression with psychotic features, and bipolar. Review of Quarterly Minimum Data Set (MDS) Assessment dated 7/8/14 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 15 indicating she was alert and oriented. The resident had no mood or behavior problems. The resident needed extensive assist with one person physical assist for bed mobility. The resident needed limited assist with one person physical assist for transfers. Interview with Assistant Activity Director on 7/24/14 at 9:15 a.m., indicated she was the person who made the activity schedule. She indicated there was a Church group that came every Saturday morning to the facility. She indicated Activity staff were not always		monitor audits in the monthly QA meeting and in the quarterly QA meeting with the Medical Director. The QA team will review audits for 6 months. Once 100% compliance is reached the QA team will determine when monitoring will stop. 5. Our Date of compliance is 8/24/2014.	

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	working on Saturdays when the church came, therefore the church group gathered the residents for church services. She indicated it depended on the time of the year of how many people came to the facility from the church group. She did indicate children also came to the facility with the church. The Assistant Activity Director indicated the church members do walk up and down the hall and invite the residents to church and she had instructed the church director they had to knock on the resident doors before entering, however, since Activity Staff were not always at the facility working on Saturdays she had no way of assuring the church members did this or not. Interview with the Activity Director on 7/24/14 at 10:20 a.m., indicated she was not aware there was a problem with that church and not knocking on the resident room doors. She indicated she would address the issue with the director today. 3. On 7/22/14 at 3:02 p.m. Resident #31 was observed sitting in her wheelchair right in front of the Nurse's Station. At that time, the Director of Nursing as well as other staff members were behind the Nurse's Station. There was also other residents seated by the Nurse's Station. The Transportation Employee walked up			

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	to Resident #31 and asked her if she was ready to go. The Director of Nursing immediately jumped into the conversation and stated in a very loud voice, "She is having that thing frozen off her face." The Transportation Employee looked up at the Director of Nursing stated "Ok." The Director of Nursing further indicated "He is doing it in the doctor's office." The record for Resident #31 was reviewed on 7/25/14 at 10:10 a.m. The resident's diagnoses included but were not limited to, dementia and depressive disorder. Review of the 7/5/14 Quarterly Minimum Data Set (MDS) Assessment indicated the resident's Brief Interview for Mental Status (BIMS) score was 10 indicating the resident had some cognitive impairment. The resident needed extensive assistance with one person physical assist for locomotion on and off the unit. Interview with the Administrator on 7/25/14 at 9:30 a.m., indicated the Director of Nursing should not have spoken so loudly about the resident's health condition. 3.1-3(t)			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure the resident's Physician Orders were followed related to a pressure ulcer treatment for 1 of 3 residents reviewed for pressure ulcers of the 3 residents who met the criteria for pressure ulcers. (Resident #12) Findings include: 1. On 7/23/14 at 10:30 a.m., LPN #1 was observed performing a pressure ulcer treatment for Resident #12. At that time the resident was observed in bed laying on her back. The resident was asked to roll onto to her left side. The pressure sore was observed in the sacral area between the resident's buttocks. The area was red with clear bloody drainage observed on the resident's incontinent brief. At that time, there was no gauze sponge observed directly covering the wound. The area was not covered. Interview with LPN #1 at 11:10 a.m. on 7/23/14, indicated there was no gauze	F000282	It is the practice of The Waters of Duneland to constitute creditable allegations of compliance with all regulatory requirements. 1. The action taken as follows: a. R 12 wound treatment was completed as ordered upon nurse identifying displacement of treatment. 2. The facility's action taken to identify others is as follows: a. 100% audit of all resident with wound treatment was completed for proper placement. No further identified. 3. The measures put into place are as follows: a. D.O.N. and/or designee will check residents on random halls with wound treatment for proper placement 5 times a week times 1 month, then 3 times a week for 3 months and then re-evaluate the need to continue. b. Nursing assistants were re-inserviced on not removing wound treatments and notifying the licensed nurse immediately if treatment is not intact. 4. The facility will monitor actions as followed: a. D.O.N. and/or designee will check residents on random halls with wound treatment for proper placement 5 times a week times	08/24/2014

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	sponge observed covering the wound after the resident's brief was pulled down and her buttocks were spread. He further indicated it could have come off during care. The record for Resident #12 was reviewed on 7/23/14 at 10:18 a.m. The resident's diagnoses included, but were not limited to, respiratory failure, anxiety, insomnia, pulmonary embolism, spinal bifida, chronic back pain, depression with psychotic features, bipolar, hypothyroidism, hyperglycemia, and hyperlipidemia. Review of Physician Orders dated 7/8/14 indicated cleanse sacral wound with normal saline. Apply fibersol to wound bed, cover with folded 4 by 4 gauze. Apply new fibersol every Tuesday, Thursday, and Saturday. Change 4 by 4 gauze twice a day and as needed (prn) for dislodgement. Interview with the Assistant Director of Nursing on 7/24/14 at 2:30 p.m., indicated she measured and kept track of all the wounds in the facility. She further indicated the gauze sponge was to be changed two times a day and as needed if it would have fallen off. She indicated the pressure ulcer should have been covered.		1 month, then 3 times a week for 3 months and then re-evaluate the need to continue. b. The Administrator and/or designee will monitor audits in the monthly QA meeting and in the quarterly QA meeting with the Medical Director. The QA team will review audits for 6 months. Once 100% compliance is reached the QA team will determine when monitoring will stop. 5. Our date of completion is 8/24/2014	

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	3.1-35(g)(2)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 3 residents reviewed for skin conditions (non-pressure related) of the 6 residents who met the criteria for skin conditions (non-pressure related). (Resident #1) Findings include: On 7/21/14 at 2:00 p.m., Resident #1 was observed with a large area of purple/bluish bruising to the top of her left hand. On 7/22/14 at 9:56 a.m., the resident was again observed with the area of purple/bluish bruising to the top of her left hand.	F000309	It is the practice of The Waters of Duneland to constitute creditable allegations of compliance with all regulatory requirements. 1. The actions taken by the facility are as follows: a. Head to toes assessment was completed on R 1. no further issues were identified. 2. The facility's action taken to identify other residents are as follows: a. No further residents were affected by the deficient practice. 3. The measures put into place by the facility are as follows: a. Re-inservice nursing staff on completing through skin assessments for any areas of discolored skin or areas of discoloration and documentation on the weekly skin assessment. 4. The facility will monitor actions as follows: a. D.O.N. and/or designee will monitor completed weekly skin assessments and observe by	08/24/2014

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	On 7/23/14 at 8:27 a.m. and 1:43 p.m., an area of dark purple discoloration was observed above the thumb area of the resident's left hand. The area of purple/bluish discoloration remained to the top of the resident's left hand. On 7/24/14 at 8:00 a.m., the resident was observed in the Rehab dining room. The area of bluish discoloration remained to the top of the resident's left hand and thumb area. The record for Resident #1 was reviewed on 7/22/14 at 2:34 p.m. A Physician's order dated 3/7/14, indicated the resident was to receive Aspirin 81 milligrams (mg) daily. Review of the Weekly Skin Sheet dated 7/18/14, indicated the resident had no areas of bruising. Review of the Weekly Skin/Wound Sheet dated 7/21/14, indicated the resident's left lower leg skin tear had healed. There was no documentation related to the bruise on the resident's left hand. A Weekly Skin Assessment dated 7/23/14 at 8:54 a.m., indicated the following: "Left hand (back) bruise 7.5 centimeters (cm) x 7.5 cm, purple bruise related to blood draw. Resident noted to		observation 5 times a week times 1 month, then 3 times a week times 3 months and then re-evaluate the need to continue. b. The Administrator and/or desigee will monitor audits in the in monthly QA meeting and in the quarterly Qa meeting with the Medical Director.The QA team will review audits for 6 months. Once 100% compliance is reached the QA team will determine when monitoring will stop. 5. Our date of compliance is 8/24/2014	

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	have purple bruise to back of left hand. No edema noted, no complaints of bruise being tender to touch. Tissue is intact. MD notified, no new orders, responsible party called, will continue to monitor." The area was identified as a "new wound." Interview with the Director of Nursing (DoN) on 7/24/14 at 10:43 a.m., indicated the bruise was observed yesterday by the Assistant Director of Nursing (ADoN) and the skin sheet was initiated. The DoN felt the bruise was due to a lab draw on 7/16/14. The DoN indicated the bruise to the left hand should have been identified on the Skin Assessment sheet dated 7/21/14. Review of the facility policy titled "Skin Condition Monitoring" on 7/24/14 at 11:42 a.m., which was provided by the DoN and identified as current, indicated the following: "When the Charge Nurse is aware of skin lesions, wounds, venous ulcers, or other skin abnormalities, the area is to be assessed and documented. Documentation of skin conditions must occur upon identification and at least once each week." 3.1-37(a)			

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F000314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services to promote healing of pressure ulcers related to ensuring treatments were completed as ordered by the Physician for 1 of 3 residents reviewed for pressure ulcers of the 3 residents who met the criteria for pressure ulcers. (Resident #12) Findings include: 1. On 7/23/14 at 10:30 a.m., LPN #1 was observed performing a pressure ulcer treatment for Resident #12. At that time the resident was observed in bed laying on her back. The resident was asked to roll onto to her left side. The pressure	F000314	It is the practice of The Waters of Duneland to constitute creditable allegations of compliance with all regulatory requirements. 1. The actions taken by the facility are as follows: a. Head to toe assessment was completed on R 1. No further issues were identified. 2. The facility's action taken to identify other residents are as follows: a. No further residents were affected by the deficient practice. 3. The measures put into place by the facility are as follows: a. Re-inserviced nursing staff on completing through skin assessments for any areas of discolored skin or areas of discoloration and documentatioon on the weekly skin assessment. 4. The facility will monitor actions as follows: a. D.O.N. and/or designee will monitor completed	08/24/2014

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	sore was observed in the sacral area between the resident's buttocks. The area was red with clear bloody drainage observed on the resident's incontinent brief. At that time, there was no gauze sponge observed directly covering the wound. The area was not covered. Interview with LPN #1 at 11:10 a.m. on 7/23/14, indicated there was no gauze sponge observed covering the wound after the resident's brief was pulled down and her buttocks were spread. He further indicated it could have come off during care. The record for Resident #12 was reviewed on 7/23/14 at 10:18 a.m. The resident's diagnoses included, but were not limited to, respiratory failure, anxiety, insomnia, pulmonary embolism, spinal bifida, chronic back pain, depression with psychotic features, bipolar, hypothyroidism, hyperglycemia, and hyperlipidemia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 7/8/14 indicated the resident's Brief Interview for Mental Status score was a 15, indicating she was alert and oriented. The resident needed extensive assist with one person physical assist for bed mobility. The resident was at risk for		weekly skin assessments and observe by observation 5 times a week times 1 month, then 3 times a week times 3 months and then re-evaluate the need to continue. b. The Administrator and/or designee will monitor audits in the monthly QA meeting and in the quarterly QA meeting with the Medical Director.The QA team review audits for 6 months. Once 100% compliance is reached the QA team will determine when monitoring will stop. 5. Our compliance date is 8/24/2014	

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	pressure ulcers and had one Stage IV pressure ulcer. Review of the current plan of care updated 7/2014 indicated the resident had a Stage IV to the sacral area. The Nursing approaches were provide treatment as ordered. Review of the Braden Scale Assessment (an assessment used to determine the risk of pressure ulcer development) dated 7/7/14 indicated the resident was a low risk for developing pressure ulcers with a score of 18. Review of Physician Orders dated 7/8/14 indicated cleanse sacral wound with normal saline. Apply fibersol to wound bed, cover with folded 4 by 4 gauze. Apply new fibersol every Tuesday, Thursday, and Saturday. Change 4 by 4 gauze twice a day and as needed (prn) for dislodgement. Review of the wound assessment dated 7/23/14 indicated the resident's pressure ulcer to her sacrum was a Stage IV. The pressure ulcer measured 4.8 centimeters (cm) by 2.5 cm by 1 cm. The tissue remains pink with no odor. The wound edges remained intact with no tunneling or undermining. No change in wound both Physicians in facility today and			

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	updated on wound. Interview with the Assistant Director of Nursing on 7/24/14 at 12:00 p.m., indicated she measured and kept track of all the wounds in the facility. She further indicated the gauze sponge was to be changed two times a day and as needed if it would have fallen off. She indicated the pressure ulcer should have been covered. 3.1-40(a)(2)			
F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program			

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	determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interview, the facility failed to ensure an infection control program was maintained related to the storage of urine collection devices and tooth brushes for 2 of 4 units throughout the facility (100 and 400 halls), as well as ensuring hand washing was being completed prior to care for 1 resident randomly observed. (Resident #50) Findings include: 1. On 7/22/14 at 9:36 a.m., and on 7/24/14 at 2:35 p.m., a white plastic container, which fits over the commode and is used to collect urine specimens, was observed on the floor behind the toilet in Room 104. The container was not wrapped in a plastic bag. Two	F000441	It is the practice of The Waters of Duneland to constitute creditable allegations of compliance with all regulatory requirements 1. The facility's actions are as follows: a. The plastic urine collection container was removed from Room 104 b. The tooth brush in Room 401 was cleaned and a plastic bag was placed over the tooth brush c. The toothbrush in Room 405 was removed d. R 50 and R 52 were not affected by the nurse's aide deficient practice of failure to wash hands in between resident contact 2. The facility's actions taken to identify other residents are as follows: a. No other residents were identified by the deficient practice 3. The measures put into place by the facility are as follows: a. 100% audit of all residents' rooms was completed. No further issues were identified by the deficient	08/24/2014

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	residents resided in this room. Interview with the Housekeeping Supervisor at the time, indicated the container should not have been in the resident's room. 2. On 7/22/14 at 9:41 a.m., in Room 401, an electric toothbrush was observed laying on the top of a 3 compartment stand. The toothbrush was not contained and the brush part was not covered. On 7/24/14 at 2:30 p.m., the electric toothbrush was observed on the 3 compartment stand. The brush part of the toothbrush was touching the toilet tank. Two residents resided in this room. Interview with the Housekeeping Supervisor at the time, indicated the top of the toothbrush should have been covered. 3. On 7/22/14 at 9:48 a.m., a toothbrush was observed on the bathroom shelf in Room 405 not contained. Two residents resided in this room. 4. On 7/24/14 at 7:20 a.m., Restorative CNA #2 was observed preparing to provide passive range of motion (PROM) exercises to Resident #52. Restorative CNA #2 entered the resident's room, she was not observed to sanitize her hands or		practice b. Staff was re-inserviced on proper placement of toothbrushes and urine collection containers c. All staff was re-inserviced on hand washing 4. The facility will monitor actions as follows: a. The Department Heads wil make rounds and monitor for proper placement of tooth brushes and urine collection containers 5 times a week. b. the Administratorand/or designeee will review results of daily rounds and ensure the concerns are addressed by the appropriate Department Head. c. D.O.N. and/or designee will randomly monitor all staff for hand washing 1 time a week times 1 month, and then monthly times 3 months, and then re-evaluate the need to continue. d. The Administrator and/or designee will monitor audits in the monthly QA meeting and in the quarterly QA meeting with the Medical Director. The QA team will review audits for 6 months. Once 100% compliance is reached the QA team will determine when monitoring will stop. 5. Our date of compliance is 8/24/2014	

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	to don clean gloves before the procedure. She was observed providing PROM exercises for the resident with non-sanitized and/or ungloved hands. The CNA then left the resident's room without being observed to sanitize her hands to retrieve a Hoyer lift (a transferring assistive device). As she transported the lift back to the resident's room, she observed Resident #50 seated in her wheelchair in the hallway outside of Resident #52's room scratching her forehead. With her non-sanitized hands she removed the resident's hands from her forehead and proceeded to wipe her hair away from her eyes. The CNA then entered Resident #52's room with the lift and at that time she was observed to wash her hands. Interview at the time with the CNA indicated she should have sanitized her hands upon completion of the PROM exercises. Review of the hand washing policy issued 7/1/11 provided by the Director of Nursing (DoN) on 7/25/14 at 10:00 a.m., indicated alcohol-based hand rub should be repeated with each resident contact. Further review of the policy indicated, "When health care personnel's hands are visibly soiled they should wash with soap and water." Interview with the DoN on 7/25/14 at			

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	11:00 a.m., indicated the CNA should have sanitized her hands before and after providing care to Resident #52. 3.1-18(a) 3.1-18(l)			
F000465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to provide a functional and sanitary environment related to marred walls and doors, stained floor tile, marred chairs, and rust stained toilet paper holders on 4 of 4 units throughout the facility. (100 hall, 200 hall, 300 hall, and 400 hall) Findings include: During the Environmental Tour on 7/24/14 at 2:20 p.m., with the Maintenance and Housekeeping Supervisors, the following was observed: 100 hall a. The inside of the bathroom door in Room 104 was paint chipped and marred. Two residents resided in this room.	F000465	It is the practice of the Watersof Duneland to constitute creditable allegations of compliance with all regulatory regulations. 1. The actions taken are as follows: a. Maintenance has looked at all doors and door frames and has developed a schedule for repairs b. Maintenance has looked at all residents room floors and developed a schedule for repairs c. All toilet paper rolls have been replaced in all resident rooms d. Maintenance has observed all resident rooms for holes and a schedule has been developed for repairs e. Maintenance has observed all resident room chairs for scratched and marred legs and a schedule has been developed for repairs f. Maintenance has observed all resident rooms' toilets for discolored caulks and a schedule has been developed for repairs 2. The facility's actions to identify others are as follows a. All rooms were observed and a	08/24/2014

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	b. The inside of the bathroom door in Room 109 was paint chipped and marred. One resident resided in this room. 200 hall a. The door to Room 202, as well as the bathroom door and door frame, were paint chipped and marred. Two residents resided in this room. b. The base of the door to Room 204 was paint chipped and marred. Two residents resided in this room. c. The floor tile located next to the heating unit in Room 209 was discolored. Two of two chairs had scratched and marred arms and legs. The base of the door to the room was paint chipped and marred. The floor tile located in front of the toilet was discolored with gray spots. Two residents resided in this room. d. The base of the door to Room 210 was paint chipped and marred. The door to the bathroom, as well as, the bathroom door frame was paint chipped and marred. The chair located next to bed A had scratched and marred legs. Two residents resided in this room. 300 hall		schedule has been developed 3. The measures put into place are as follows: a. A schedule has been developed 4. The facility will monitor as follows: a. The Administrator will monitor resident's rooms for scheduled maintenance 3 times weekly times 3 months b. The Administrator and/or designee will monitor audits in the monthly QA meetings and in the quarterly QA meeting with the Medical Director.The QA team will review audits for 6 months. Once 100% compliance is reached the QA team will determine when monitoring will stop. 5. Our compliance date is 8/24/2014	

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	a. There was a hole in the wall behind the door in Room 307. Two residents resided in this room. b. The door to the bathroom in Room 312 was paint chipped and marred. Two residents resided in this room. 400 hall a. The inside of the bathroom door and the bathroom door frame were paint chipped and marred. Two residents resided in this room. b. The bathroom door and door frame as well as the door to Room 402, were paint chipped and marred. Two residents resided in this room. c. The inside of the bathroom door and the door frame were paint chipped and marred in Room 405. Two residents resided in this room. d. The bathroom door and door frame were paint chipped and marred in Room 411. Two residents resided in this room. e. The bathroom door and door frame in Room 413 were paint chipped and marred. The wall next to the closet was gouged and marred. The toilet paper holder was rusted and loose. Two			

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	residents resided in this room. f. The base of the wall in Room 414 was paint chipped and marred. The door to the bathroom and the door frame were paint chipped and marred. The toilet paper holder had areas of rust. The caulking around the base of the toilet was discolored. Two residents resided in this room. Interview with the Maintenance Supervisor at the time, indicated all of the above areas were in need of repair. 3.1-19(f)			
F000498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, record review and interview, the facility failed to ensure CNAs did not practice our of their realm related to removing gauze sponges to pressure ulcers for 1 of 3 residents reviewed for pressure ulcers of the 3	F000498	It is the practice of The Waters of Duneland to constitute creditable allegations of compliance with all regulatory regulation 1. The actions taken by the facility are as follows: a. C.N.A. removed wound dressing of R 12 2. The facility's actions to identify others	08/24/2014

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	residents who met the criteria for pressure ulcers. (Resident #12) Findings include: 1. On 7/23/14 at 10:30 a.m., LPN #1 was observed performing a pressure ulcer treatment for Resident #12. At that time the resident was observed in bed laying on her back. The resident was asked to roll onto to her left side. The pressure sore was observed in the sacral area between the resident's buttocks. The area was red with clear bloody drainage observed on the resident's incontinent brief. At that time, there was no gauze sponge observed directly covering the wound. The area was not covered. Interview with LPN #1 at 11:10 a.m. on 7/23/14, indicated there was no gauze sponge observed covering the wound after the resident's brief was pulled down and her buttocks were spread. He further indicated it could have come off during care. He indicated he was not made aware the dressing had fallen off or was removed. Interview with CNA #1 on 7/23/24 at 11:12 a.m., indicated she had taken care of the resident today. She indicated she had turned and repositioned the resident and had changed the resident's brief after		are as follows: a. No further residents were identified r/t deficient practice 3. The measures put into place are as follows: a. All C.N.A.'s were re-educated and re-inserviced on not removing wound dressing 4. The facility will monitor actions as follows; a. D.O.N. and/or designee will randomly monitor certified nursing assistants perform resident care to assure C.N.A.'s are practicing within their realm 5 times a week times 1 month, then 3 times a week times 3 months and then will determine the need to continue. b. The administrator/or designee will monitor audits in the monthly QA meeting and in the quarterly QA meeting with the Medical Director. The QA team will review audits for 6 months. Once 100% compliance is reached the QA team will determine when monitoring will stop. 5. Our date of compliance is 8/24/2014	

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	breakfast which was about 9:30 a.m. The CNA indicated she had removed the gauze sponge that was directly on the pressure sore because it had a lot of drainage on it. She then indicated she had not informed the nurse what she had done because she had gotten side tracked with other things. The record for Resident #12 was reviewed on 7/23/14 at 10:18 a.m. The resident's diagnoses included, but were not limited to, respiratory failure, anxiety, insomnia, pulmonary embolism, spinal bifida, chronic back pain, depression with psychotic features, bipolar, hypothyroidism, hyperglycemia, and hyperlipidemia. Review of Physician Orders dated 7/8/14 indicated cleanse sacral wound with normal saline. Apply fibersol to wound bed, cover with folded 4 by 4 gauze. Apply new fibersol every Tuesday, Thursday, and Saturday. Change 4 by 4 gauze twice a day and as needed (prn) dislodgement. Interview with the Assistant Director of Nursing on 7/24/14 at 12:00 p.m., indicated she measured and kept track of all the wounds in the facility. She further indicated the gauze sponge was to be changed two times a day and as needed if			

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	it would have fallen off. She indicated the CNA should not have removed the gauze sponge from the pressure ulcer. 3.1-14(i)			